Appendix F
Matrix of Healthy Start Standards and Criteria

Healthy Start Standards & Criteria
2007
The following standards and criteria guide the implementation of Florida's Healthy Start.

Topic	Standards & Criteria
Chapter 2: Outreach – Participant Identification, Provider Recruitment, and Community Education	**Standard 2.1 The Healthy Start coalition will assure, through performance based contract or memorandum of agreement, that communities receive education and information about the Healthy Start program and services. This education must include how to access Healthy Start services and where services are available. Communities include, but are not limited to, potential participants, health care providers, social service agencies, and community based organizations.** *Criteria:* **2.1.a** All providers receive education and information on the Healthy Start initiative and Healthy Start programs and services annually. **2.1.b** All educational and outreach information is developed and disseminated with consideration of the culture, language, education, and literacy of the participants, as well as their ability to access community resources. **2.1.c** All SOBRA prenatal care providers receive education and information on the standards of care addressed in the Medicaid Waiver and/or established by the Statewide Medicaid Waiver Workgroup. **Standard 2.2 The Healthy Start coalition's service delivery plan update will include evaluation of the effectiveness of outreach activities.** *Criterion:* The effectiveness of participant identification, public and private provider recruitment, and community education activities is evaluated and documented in the service delivery plan update.

	Standards & Criteria
Chapter 2: Outreach – Participant Identification, Provider Recruitment, and Community Education (Cont.)	**Standard 2.3 The Healthy Start coalition will assure that there is a designated provider for screening, assessment, and determination of Presumptive Eligibility for Pregnant Women (PEPW**). *Criteria:* **2.3.a** Pregnant women with incomes equal to or less than 185 percent of poverty access PEPW within two weeks of first contact seeking prenatal care. **2.3.b** All providers receive information and education regarding PEPW. **Standard 2.4 The Healthy Start coalition will collaborate with the Department of Children and Families district offices in the development and maintenance of a local operating procedure for the Simplified Eligibility process.** Criteria: 2.4.a. Pregnant women with incomes equal to or less than 185 percent of poverty complete Simplified Eligibility form at the verification of pregnancy. 2.4.b. All providers receive information and education regarding Simplified Eligibility. **Standard 2.5 The Healthy Start coalition will assure there is a system in place for providing prenatal care outreach (MomCare) to SOBRA women and ensuring participant entry into prenatal care.** *Criteria:* **2.5.a.** Provider adherence to standards of care is monitored annually and documented as part of the QI process. **2.5.b.** The effectiveness of prenatal care outreach is evaluated annually and reflected in QI documentation.

	Standards & Criteria
Chapter 2: Outreach – Participant Identification, Provider Recruitment, and Community Education (Cont.)	**2.5.c.** The effectiveness of partnering efforts with the community for prenatal care outreach is evaluated annually and reflected in Quality Improvement (QI) and Quality Assurance (QA) documentation.
Chapter 3: Healthy Start Risk Screening	**Standard 3.1 The Healthy Start coalition will assure that providers receive training on how to present the Healthy Start screen in a manner that encourages consent, and how to explain the concept of Healthy Start as well as the benefits of Healthy Start screening.** *Criteria:* **3.1.a** Healthy Start coalition designates responsibility for training prenatal care providers and birth facilities staff who provide Healthy Start screening. **3.1.b** Documentation of training is included in the coalition progress reports. The documentation includes training dates, participants (individual or group), and curriculum determined by the coalition. **Standard 3.2 Each Healthy Start coalition will assure the development and implementation of a public relations strategy designed to achieve universal Healthy Start prenatal and infant risk screening.** *Criteria:* **3.2.a** All providers of Healthy Start care coordination participate in the development and implementation of the strategy. **3.2.b** All training and education related to Healthy Start screening is provided with consideration to cultural, language, educational/literacy, and accessibility needs of the participant.

	Standards & Criteria
Chapter 3: Healthy Start Risk Screening (Cont.)	**Standard 3.3 All prenatal care providers and delivering facilities will use the Healthy Start prenatal and infant risk screening instruments designated by the Department of Health and provided by the county health department.** *Criteria:* **3.3.a** Each provider forwards the completed Healthy Start risk screening form within five working days of completion of the screen to the county health department in the county where screening occurred. **3.3.b** Each county health department where the screening occurs checks the screens for accuracy, obtains corrections as necessary, and then forwards the appropriate copies of the Healthy Start screen to the county health department in the participant's county of residence or enters the screening form data into the Healthy Start prenatal screening module as appropriate, within five working days. **3.3 c.** The county health department in the participant's county of residence enters the screening form data into the Healthy Start prenatal screening module, and then forwards all screens with program consent and referral to the Healthy Start care coordinator within five days. Information release consent is required if care coordination is provided outside of the county health department. Additionally, each county Healthy Start program forwards a copy of all Healthy Start screens on which the participant responds "yes" to consent for release of information to the Healthy Families Florida (HFF) provider (where available), unless otherwise determined by local agreement with Healthy Families. Healthy Start staff does not calculate HFF risk scores. Cost sharing of the screening forms copies shall be based on local agreement between Healthy Start and Healthy Families Florida. **Standard 3.4 Each Healthy Start coalition's and county health department's quality management/program improvement system will include a Healthy Start screening component.** *Criterion:* The QM/PI screening component consists of, at a minimum, an annual review and assessment of screening reports identifying critical screening issues and plans to address problems.

	Standards & Criteria
Chapter 3: Healthy Start Risk Screening (Cont.)	**Standard 3.5 Each Healthy Start care coordinator and coalition will receive updated technical assistance and/or training related to Healthy Start screening.** *Criterion:* Information provided through technical assistance and/or training is disseminated to each Healthy Start care coordinator and coalition through a locally determined mechanism.
Chapter 4: Healthy Start Care Coordination and Risk Appropriate Care	**Standard 4.1 Healthy Start services will be delivered according to identified risk and need.** *Criteria:* **4.1.a** The extent of services is based on available local resources. **4.1.b** Services are provided at varying levels of intensity based on identified risk and need for services. **4.1.c** Provision of services reflects sensitivity to cultural, language, educational/literacy, and accessibility needs. **Standard 4.2 Healthy Start care coordination service delivery and caseload management will be prioritized in a manner that addresses the immediacy of the participant's needs and identified risks to improve outcomes.** *Criterion:* The order of priority for care coordination service delivery to Healthy Start participants is based on: 1) Safety concerns and immediate needs identified in Table 4.2 a of this chapter 2) Severity of risk and need 3) Participant's motivation to address risk/need 4) Ability to provide services that link to participant's risk and are likely to have a positive impact on outcomes 5) Participant's ability to access other community resources available to offset the risk/need

	Standards & Criteria
Chapter 4: Healthy Start Care Coordination and Risk Appropriate Care (Cont.)	**Standard 4.3 Providers of Healthy Start funded care coordination services will accurately code service information in a timely manner for data entry into the Health Management System (HMS).** *Criterion:* Coding complies with the requirements of the Department of Health publication DHP 50-20. **Standard 4.4 Providers of Healthy Start care coordination services will document services in the participant's existing clinical record or, in the absence of a clinical record, in an individual record format determined by the local coalition and service provider.** *Criteria:* **4.4.a** Services are documented in the record of the individual receiving the services. In the event that services are provided to another person on behalf of a Healthy Start program participant, the services are only referenced in the Healthy Start participant's record. The actual detailed documentation occurs in the record of the individual receiving the service. For example, if the mother of a Healthy Start child participant is being provided with tobacco cessation counseling, the actual documentation occurs in the mother's record, since she is receiving the service; however, the service is also referenced in the child's record. **4.4.b** Authorization for release of medical information is requested from every participant receiving a face to face contact. 1) If the release is refused, the refusal is documented in the participant's record and information will not be released. 2) If the release is obtained, the original form is maintained in the participant's record. **4.4.c** The following services and activities, when provided, are documented in the participant's record: 1) A copy of the participant's Healthy Start risk screening form or documentation of Healthy Start risks if referred by community provider or self referred 2) At a minimum, all attempts, successful and unsuccessful, to contact the potential program participant 3) All interactions with the program participant, the family, or with others impacting their receipt of services 4) Identified risks, needs, and individualized plan of care for addressing or rationale for not addressing the risks and needs 5) Activities related to initial contact, initial assessment, and ongoing care coordination, including

	Standards & Criteria
Chapter 4: Healthy Start Care Coordination and Risk Appropriate Care (Cont.)	tracking, provision of referrals and follow-up activities, Individualized Plan of Care (IPC) updates, and health related education 6) A family support plan for all Level 3 Healthy Start participants using the process of the one-page Family Support Plan (DH 3151), or the six-page Family Support Plan when applicable 7) Follow-up with the participant's health care provider **Standard 4.5 In conjunction with the participant, the care coordination provider will facilitate access to adequate health care.** *Criterion:* At a minimum, care coordination providers will evaluate the participant's ability to access and, if necessary, facilitate access to: Medicaid and Title XXI eligibility determination including Presumptive Eligibility for Pregnant Women (PEPW) and Simplified Eligibility for Pregnant Women (SEPW), 1) Prenatal and postpartum care, 2) Child primary health care including Child Health Check Up for Medicaid eligible children, 3) Up-to-date immunization services, 4) Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), 5) Other Healthy Start services, and 6) Family planning services if the mother is postpartum or being served interconceptionally. **Standard 4.6 Care coordination providers will participate in the development of collaborative networks of care within the community and will refer and/or transition care to specialized community providers with whom they have interagency agreements.** *Criterion:* At a minimum, care coordination providers comply with the following interagency agreements: 1) Early Steps, Children's Medical Services; 2) Neonatal Intensive Care Units for NICU clients; 3) Regional Perinatal Intensive Care Centers (RPICC) and other Level III Centers; 4) Children's Medical Services for Children with Special Health Care Needs; Department of Children and Families for pregnant, substance abusing women and substance exposed children; 5) County health departments in the event the county health department is not the sole provider of care coordination; and

	Standards & Criteria
Chapter 4: Healthy Start Care Coordination and Risk Appropriate Care (Cont.)	6) Healthy Families Florida projects. **Standard 4.7 The Healthy Start care coordinator will facilitate the participant's access to other health care funding options and resources through provision of appropriate referrals.** *Criteria:* **4.7.a** The care coordinator is knowledgeable about eligibility requirements and fees for other services. **4.7.b** The care coordinator is knowledgeable about other funding sources, such as county service dollars, local agency services or funding, grant sources, private funds, and insurance services, such as Medicaid services. **4.7.c** The care coordinator is knowledgeable about Florida's Family Health Line, a statewide toll-free number (1-800-451-2229) for basic information and referrals for prenatal, infant and family health. **Standard 4.8 Healthy Start care coordination services will be provided by qualified and trained providers. Each agency providing care coordination will have a written orientation plan with checklist sign off for their personnel file.** *Criteria:* **4.8.a** Qualifications and competencies are met as specified in this chapter or as specified in Chapter 64F-3, F.A.C. **4.8.b** Paraprofessionals work under the direct supervision of a qualified professional and adhere to the additional requirements as specified in the provider qualifications section of this chapter. **4.8.c** All providers of care coordination services receive a minimum of two weeks pre-service training on the Healthy Start program and home visiting and/or demonstrate competencies as specified in this chapter. **4.8.d** Competency and up-to-date knowledge related to Healthy Start care coordination are maintained. Training certifications shall be placed in personnel files. **4.8.e** Training materials that are provided by the department and locally adapted resources are utilized.

	Standards & Criteria
Chapter 4: Healthy Start Care Coordination and Risk Appropriate Care (Cont.)	**4.8.f** All providers will be knowledgeable of Department of Health (DOH) Information Security Privacy Policies including confidentiality, managing the security and confidentiality of data, and other security requirements. **4.8.g** All providers participate in ongoing locally provided training. **4.8.h** All providers receive pre-service training to include the following: risk screenings, child abuse, domestic violence, etc. on recognizing and reporting abuse and neglect. **Standard 4.9 Care coordination service providers will develop and implement an internal quality management (QM) and program improvement (PI) process.** *Criterion:* The QM/PI process is developed in concert with the local Healthy Start coalition and includes an assessment of strengths and weaknesses to identify areas for quality maintenance and program improvement, as specified in the standards in Chapter 17, "Quality Management/Program Improvement (QM/PI) for Healthy Start Providers and Coalitions." **Standard 4.10 Healthy Start participants will receive an initial contact.** *Criteria:* **4.10.a** Participants receive an initial contact or attempt at initial contact within five working days of the receipt of the screen or the referral to Healthy Start care coordination services. If the initial attempt to contact is not successful, an additional attempt to contact will be made within ten working days of the first attempt. The third attempt to contact will be made within ten working days of the second attempt. **4.10.b** At a minimum, the initial contact includes all initial contact service delivery activities specified in this chapter (Chapter 4). **4.10.c** Written notification of the status of the initial contact and plan for further services or closure are provided to the prenatal care provider or child's primary care provider within 30 calendar days of the first attempt to contact. If the child's primary care provider is not known, document in the case file why written notification is not possible.

	Standards & Criteria
Chapter 4: Healthy Start Care Coordination and Risk Appropriate Care (Cont.)	**4.10.d** If a referral has been made to Healthy Start due to risk of child maltreatment, written notification of the status of the initial contact and plan for further services or closure are provided to the referral source within 30 calendar days of the first attempt to contact. **Standard 4.11 All Healthy Start participants will be assigned a level based on their service needs.** *Criteria:* **4.11.a** At a completed initial contact, a level of care defined as level E, level 1, level 2, or level 3 will be assigned to the participant. The participant who has not had a completed initial contact will be assigned a level pending (P) status. The level shall reflect the risk and severity of service needs. The greater the risk and service need, the higher the level assigned to the participant. **4.11.b** Levels are assigned based on professional judgment using risk appropriate care principles. Levels are fluid and fluctuate based on changes in the participant's status. The initial level or change in level must be supported by documentation. **Standard 4.12 All Healthy Start participants will have an Individualized Plan of Care.** *Criteria:* **4.12.a** The Individualized Plan of Care (IPC) is a written plan of identified needs, goals, interventions, and progress towards meeting the goal(s) based on the care coordinator's evaluation of the participant's risks and needs. **4.12.b** The IPC is initiated at the initial contact, and is re-evaluated at each subsequent encounter. **Standard 4.13 A Healthy Start initial assessment will be provided to all participants determined as needing such at the initial contact.** *Criteria:* **4.13.a** A face to face initial assessment of service needs is completed or attempted within 10 working days after the date of the completed initial contact on every woman, infant, and/or child identified as needing an initial assessment.

	Standards & Criteria
Chapter 4: Healthy Start Care Coordination and Risk Appropriate Care (Cont.)	**4.13.b** At a minimum, the initial assessment includes all service delivery activities specified in the initial assessment section of this chapter (Chapter 4). **4.13.c** Each pregnant or interconception woman or infant/child who has been assessed to be in need of other Healthy Start and/or community services is referred to a qualified provider within five working days. **4.13.d** Initial assessment evaluates risk factors, corresponding need, resources, and potential for change. **4.13.e** A phone call or written note is provided to the prenatal care provider or infant's/child's primary care provider within 30 calendar days of the initial contact and the initial assessment regarding findings, request for collaboration, and outline for the disposition of the case. **Standard 4.14 Healthy Start ongoing care coordination services will be provided to all participants who are determined to need them.** *Criteria:* **4.14.a** Ongoing care coordination services are provided by risk appropriate criteria. **4.14.b** Family support planning is done with all participants in need of high risk ongoing care coordination based on the criteria of the leveling system. **4.14.c** Ongoing care coordination: 1) Addresses risk factors and their underlying situations, 2) Is based on identified needs and resources as outlined in the Individualized Plan of Care and the Family Support Plan if applicable, and 3) Includes all related service delivery activities specified in this chapter (Chapter 4). **4.14.d** The care coordination provider addresses each risk factor identified as having potential for change through goal setting and plan development with the pregnant/interconception woman or family of the child. When the participant or family chooses not to address a risk factor, this will be documented in the participant's record.

	Standards & Criteria
Chapter 4: Healthy Start Care Coordination and Risk Appropriate Care (Cont.)	**4.14.e** Notification of significant change (i.e. safety needs, mental health issues) in the participant's status or plan is provided to the prenatal care provider or infant's/child's primary care provider. **Standard 4.15 All Healthy Start participants assigned a level 3 will have a Family Support Plan.** *Criteria:* **4.15.a** The family support plan will be required for level 3 participants and will be updated at least every three months. The initial family support plan will be facilitated through a face to face interaction with the participants (see narrative page 69). **4.15.b** The family support planning process may be utilized with all Healthy Start participants; however, this activity may only be coded in the HMS system for level 3 participants. **4.15.c** As noted in Chapter 12, a family support plan is required for all pregnant substance abusing pregnant women and substance exposed infants. **Standard 4.16 Participants may be closed to HS care coordination when determined to no longer need or desire care coordination services or are receiving care coordination services from another agency. Other HS services (breastfeeding, parenting, psychosocial counseling, smoking cessation, and interconception) may continue to be provided to the HS participant who no longer requires HS care coordination. Participants may be reopened to Healthy Start care coordination if their needs change**. *Criteria:* **4.16.a** At a minimum, three attempted contacts are made before closing as lost to contact any participant who has scored 4 or higher on the Healthy Start screen or who has been referred for safety concerns and immediate needs as defined in Tier 1, Table 4.2a of this chapter. At least one attempt at face to face contact will be made. **4.16.b** For participants with safety concerns and immediate needs as described in this chapter, every effort to locate the participant is made and documented, including letters, telephone calls, attempts to make face to face contact, and the following: 1) Contact with the participant's health care provider to verify his/her address and telephone number;

	Standards & Criteria
Chapter 4: Healthy Start Care Coordination and Risk Appropriate Care (Cont.)	2) Contact with Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) staff; 3) Contact with county health department (CHD) immunizations staff; and 4) Contact with FLORIDA Medicaid Management Information System (FMMIS) where available. **4.16.c** Care coordination closure activities include: 1) Assessment of the need for referrals to other Healthy Start services, community services, primary care, family planning, interconception counseling, and assisting in accessing these services; 2) Notification of the prenatal or primary care provider of closure and collaboration in the event the provider recommends additional services; 3) Notification of referral source and/or Department of Children and Families when referral reason was risk of child maltreatment; 4) When appropriate, transition to another care coordination provider with release of information and record transfer; 5) Providing the participant with information regarding the ability to return as a program participant if necessary and the participant remains eligible; and 6) Documentation of IPC goals, birth and health outcomes, as appropriate.
Chapter 5: Healthy Start Services Breastfeeding Education and Support	**Standard 5.1 Healthy Start breastfeeding education and support services will be offered to all participants who are determined through the care coordination process to need them.** ***Criteria:*** **5.1.a** Level of service is based upon local resources, local Healthy Start coalition funding decisions, and consideration of Healthy Start as the payer of last resort. **5.1.b** Breastfeeding education and support services are provided with consideration to the cultural, language, educational/literacy, and accessibility needs of the participant. **5.1.c** With the participant's approval, the infant's father, significant others, and other household members are encouraged to participate in the education process. **5.1.d** Breastfeeding education and support includes at least one face-to-face contact, an assessment of current infant feeding status, counseling consistent with the breastfeeding plan of care and

	Standards & Criteria
Chapter 5: Healthy Start Services Breastfeeding Education and Support (Cont.)	documentation based on goals, and referrals to local breastfeeding support groups or other support sources. **5.1.e** Prenatal breastfeeding education includes anticipatory education on barriers to breastfeeding and on breastfeeding in the early postpartum period, exclusivity, and continuation. **5.1.f** A breastfeeding plan of care is written to include specific breastfeeding outcome goals that involve the woman in her own care. **5.1.g** All educational materials and breastfeeding promotion and support activities comply with the World Health Organization Code of Marketing of Breastmilk Substitutes. **Standard 5.2 The provider of breastfeeding education and support services will provide follow-up to the Healthy Start care coordinator.** *Criterion:* Written follow-up documenting receipt of referral and plan for initiation of services is provided to the Healthy Start care coordinator within 30 days. **Standard 5.3 Providers of breastfeeding education and support services will offer and initiate services in a timely manner.** *Criteria:* **5.3.a** For prenatal participants, services are initiated within 30 days after receipt of referral or identified need unless the need for more immediate initiation of services is evident. **5.3.b** For postpartum participants, services are initiated within three days after receipt of referral or identified need unless the need for more immediate initiation of services is evident. **Standard 5.4 Providers of breastfeeding education and support services will respond to any additional identified needs.**

	Standards & Criteria
Chapter 5: Healthy Start Services Breastfeeding Education and Support (Cont.)	*Criteria:* **5.4.a** Additional identified needs are addressed directly by the provider or by notifying the participant's Healthy Start care coordinator. **5.4.b** Breastfeeding education and support providers communicate with the care coordinator who develops the family support plan and collaborates as a part of the interdisciplinary team as indicated by individual need. **Standard 5.5 Providers of Healthy Start funded breastfeeding education and support services will accurately code service information in a timely manner for Health Management System (HMS) data entry.** *Criterion:* Coding complies with the requirements of the Department of Health publication DHP 50-20. **Standard 5.6 Providers of breastfeeding education and support services will document services in the participant's existing clinical record or, in the absence of a clinical record, in a format determined by the local coalition and provider.** *Criteria:* **5.6.a** Documentation of services is recorded in the record of the individual receiving services. In the event that services are provided to another person on behalf of a Healthy Start program participant, the services are only referenced in the Healthy Start program participant's record. The actual detailed documentation occurs in the record of the individual receiving the service. For example, if the mother of a Healthy Start child participant is being provided with breastfeeding education, the actual documentation occurs in the mother's record, since she is receiving the service; however, the service is also referenced in the child's record. **5.6.b** Documentation occurs in other components of the record such as the problem list or family support plan as appropriate.

	Standards & Criteria
Chapter 5: Healthy Start Services Breastfeeding Education and Support (Cont.) Chapter 6: Healthy Start Services Childbirth Education	**Standard 5.7 Breastfeeding education and support service providers will develop and implement an internal quality management (QM) and program improvement (PI) process.** *Criterion:* The QM/PI process is developed in concert with the local Healthy Start coalition and includes an assessment of strengths and areas needing improvement and a plan for assuring maintenance of quality and program improvement. **Standard 5.8 Breastfeeding education and support services will be provided by qualified and trained providers.** *Criteria:* **5.8.a** Qualifications are met as outlined in this chapter and as specified in rule 64F- 3.006(7), F.A.C. **5.8.b** Competency and up-to-date knowledge related to breastfeeding education and support services is maintained. **Standard 6.1 Healthy Start childbirth education services will be offered to all participants who are determined through the care coordination process to need them.** *Criteria:* **6.1.a** Level of service is based upon local resources, local Healthy Start coalition funding decisions, and consideration of Healthy Start as the payer of last resort. **6.1.b** Childbirth education is provided with consideration to the cultural, language, educational/literacy, and accessibility needs of the participant. **6.1.c** With the participant's approval, the infant's father, significant others, and other household members are encouraged to participate in the education process. **6.1.d** Childbirth education follows an established and approved curriculum that includes topics described in the Guidelines section of this chapter. **6.1.e** The duration of childbirth education classes is specified in contracts or memoranda of agreement.

	Standards & Criteria
Chapter 6: Healthy Start Services Childbirth Education (Cont.)	**Standard 6.2 The provider of childbirth education services will provide follow-up to the Healthy Start care coordinator**. *Criterion:* Written follow-up documenting receipt of referral and plan for initiation of services is provided to the Healthy Start care coordinator within 30 days. **Standard 6.3 Providers of childbirth education services will offer and initiate services in a timely manner.** *Criterion:* Providers of childbirth education will contact participants at least 90 days before the estimated delivery date or at the time of the referral or identified need if during the third trimester of pregnancy to initiate a plan of care for receipt of services. **Standard 6.4 Providers of childbirth education will respond to any additional identified needs.** *Criteria:* **6.4.a** Additional identified needs are addressed directly by the provider or by notifying the participant's Healthy Start care coordinator. **6.4.b** Childbirth education providers communicate with the care coordinator who develops the family support plan and will collaborate as a part of the interdisciplinary team as indicated by individual need. **Standard 6.5 Providers of childbirth education will accurately code service information in a timely manner for Health Management System (HMS) data entry.** *Criterion:* Coding complies with the requirements of the Department of Health publication DHP 50-20. **Standard 6.6 Providers of childbirth education will document services in the participant's existing clinical record or, in the absence of a clinical record, in a format determined by the local coalition and provider**.

	Standards & Criteria
Chapter 6: Healthy Start Services Childbirth Education (Cont.)	*Criteria:* **6.6.a** Documentation of services is recorded in the record of the individual receiving services. In the event that services are provided to another person on behalf of a Healthy Start program participant, the services are only referenced in the Healthy Start program participant's record. The actual detailed documentation occurs in the record of the individual receiving the service. **6.6.b** Documentation occurs in other components of the record such as the problem list or family support plan as appropriate. **Standard 6.7 Childbirth education providers will develop and implement an internal quality management (QM) and program improvement (PI) process.** *Criterion:* The QM/PI process is developed in concert with the local Healthy Start coalition and includes an assessment of strengths and areas needing improvement and a plan for assuring maintenance of quality and program improvement. **Standard 6.8 Childbirth education will be provided by qualified and trained providers.** *Criteria:* **6.8.a** Qualifications are met as outlined in this chapter and as specified in rule 64F-3.006(2), F.A.C. **6.8.b** Competency and up-to-date knowledge related to childbirth education is maintained.
Chapter 7: Healthy Start Nutrition Counseling	**Standard 7.1 Healthy Start nutrition counseling services will be offered to all participants who are determined through the care coordination process to be in need of nutrition services.** *Criteria:* **7.1.a** Level of service is based upon local resources, local Healthy Start coalition funding decisions, and consideration of Healthy Start as the payer of last resort.

	Standards & Criteria
Chapter 7: Healthy Start Nutrition Counseling (Cont.)	**7.1.b** Nutrition counseling is provided with consideration to the cultural, language, educational/literacy, and accessibility needs of the participant. **7.1.c** With participant's approval, infants' fathers, significant others, and other household members are encouraged to participate in the counseling process. **7.1.d** Nutrition counseling includes the following components: diagnostic assessment, development of a plan of care, counseling consistent with the plan of care, and evaluation of progress. **Standard 7.2 The provider of nutrition counseling will provide follow-up to the Healthy Start care coordinator.** *Criterion:* Written follow-up documenting receipt of referral and plan for initiation of services is provided to the Healthy Start care coordinator within 30 days. **Standard 7.3 Providers of nutrition counseling will offer and initiate services in a timely manner.** *Criterion:* Nutrition counseling is initiated within 30 days after receipt of referral or identified need unless the need for more immediate initiation of services is evident. **Standard 7.4 Providers of nutrition counseling will respond to any additional identified needs.** *Criteria:* **7.4.a** Additional identified needs are addressed directly by the provider or by notifying the participant's Healthy Start care coordinator. **7.4.b** Nutrition counseling providers communicate with the care coordinator who develops the family support plan and will collaborate as a part of the interdisciplinary team as indicated by individual need. **Standard 7.5 Providers of nutrition counseling will accurately code service information in a timely manner for Health Management System (HMS) data entry.**

	Standards & Criteria
Chapter 7: Healthy Start Nutrition Counseling (Cont.)	*Criterion:* Coding complies with the requirements of the Department of Health publication DHP 50-20. **Standard 7.6 Providers of nutrition counseling will document services in the participant's existing clinical record or, in the absence of a clinical record, in a format determined by the local coalition and provider.** *Criteria:* **7.6.a** Services are documented in the record of the individual receiving the services. In the event that services are provided to another person on behalf of a Healthy Start program participant, the services are only referenced in the Healthy Start participant's record. The actual detailed documentation occurs in the record of the individual receiving the service. For example, if the mother of a Healthy Start child participant is being provided with nutrition counseling, the actual documentation occurs in the mother's record, since she is receiving the service; however, the service is also referenced in the child's record. **7.6.b** Documentation occurs in other components of the record, such as the problem list or family support plan, as appropriate. **Standard 7.7 Nutrition counseling providers will develop and implement an internal quality management (QM) and program improvement (PI) process.** *Criterion:* The QM/PI process is developed in concert with the local Healthy Start coalition and includes an assessment of strengths and areas needing improvement and a plan for assuring maintenance of quality and program improvement. **Standard 7.8 Nutrition counseling will be provided by qualified and trained providers.** *Criteria:* **7.8.a** Qualifications are met as outlined in this chapter and as specified in statute and rules, Chapter 468, Part X, F.S., and Chapter 64B 8-40 to 8-45, F.A.C. **7.8.b** Competency and up-to-date knowledge related to nutrition counseling is maintained.

	Standards & Criteria
Chapter 8: Healthy Start Services Parenting Education and Support	**Standard 8.1 Healthy Start parenting education and support services will be offered to all participants who are determined through the care coordination process to need them.** *Criteria:* **8.1.a** Level of service is based upon local resources, local Healthy Start coalition funding decisions and consideration of Healthy Start as the payer of last resort. **8.1.b** Parenting education and support will be provided with consideration to the cultural, language, educational/literacy and accessibility needs of the participant. **8.1.c** With the participant's approval, fathers, significant others, and other household members are encouraged to participate in the education process. **8.1.d** Parenting education and support includes the following components: • Assessment, • Development of a plan of care, • Counseling and education consistent with the plan of care that includes presentation, a demonstration activity, and follow-up and feedback, and, • Evaluation of progress. **8.1.e** Parenting education and support follows an established curriculum approved by the Healthy Start Coalition. **8.1.f** Providers of parenting education and support assure classes and support services are prevention-based and /or intervention-based, and adaptable to reflect parental needs. **8.1.g** The duration of parenting education classes or individual sessions is specified in contracts and/or memoranda of agreement. **8.1.h** Parenting education and support includes at least one information session and additional sessions based on identified need.

	Standards & Criteria
Chapter 8: Healthy Start Services Parenting Education and Support (Cont.)	**Standard 8.2 The provider of parenting education and support services will provide follow-up information to the Healthy Start care coordinator.** *Criterion:* Written follow-up documenting receipt of referral and plan for initiation of services is provided to the Healthy Start care coordinator within 30 days. **Standard 8.3 Providers of parenting education and support services will offer and initiate services in a timely manner.** *Criterion:* Parenting education and support services are initiated within 30 days after receipt of referral or identified need unless the need for more immediate initiation of services is evident. **Standard 8.4 Providers of parenting education and support will respond to any additional identified needs.** *Criteria:* **8.4.a** Additional identified needs are addressed directly by the provider or by notifying the participant's Healthy Start care coordinator. **8.4.b** Parenting education and support providers communicate with the care coordinator who develops the family support plan, and will collaborate as a part of the interdisciplinary team as indicated by individual need. **Standard 8.5 Providers of parenting education and support will accurately code service information in a timely manner for Health Management System (HMS) data entry.** *Criterion:* Coding complies with the requirements of the Department of Health publication DHP 50-20.

	Standards & Criteria
Chapter 8: Healthy Start Services Parenting Education and Support (Cont.)	**Standard 8.6 Providers of parenting education and support will document services in the participant's existing clinical record or, in the absence of a clinical record, in a format determined by the local coalition and provider.** *Criteria:* **8.6.a** Services are documented in the record of the individual receiving the services. In the event that services are provided to another person on behalf of a Healthy Start program participant, the services are only referenced in the Healthy Start participant's record. The actual detailed documentation occurs in the record of the individual receiving the service. For example, if the mother of a Healthy Start child participant is being provided with parenting education and support, the actual documentation occurs in the mother's record, since she is receiving the service; however, the service is also referenced in the child's record. **8.6.b** Documentation occurs in other components of the record such as the problem list or family support plan, as appropriate. **Standard 8.7 Parenting education and support providers will develop and implement an internal quality management (QM) and program improvement (PI) process.** *Criterion:* The QM/PI process is developed in concert with the local Healthy Start coalition and includes an assessment of strengths and areas needing improvement and a plan for assuring maintenance of quality and program improvement. **Standard 8.8 Parenting education and support will be provided by qualified and trained providers.** *Criteria:* **8.8.a** Qualifications are met as outlined in this chapter and as specified in rule 64F-3, F.A.C.

	Standards & Criteria
Chapter 8: Healthy Start Services Parenting Education and Support (Cont.)	**8.8.b** Competency and up-to-date knowledge related to parenting education and support is maintained.
Chapter 9: Healthy Start Services Psychosocial Counseling	**Standard 9.1 Healthy Start psychosocial counseling services will be offered to all participants who are determined through the care coordination assessment process to need them.** *Criteria:* **9.1.a** Level of service is based upon severity of symptoms as well as availability of local resources, local Healthy Start coalition funding decisions, and consideration of Healthy Start as the payer of last resort. **9.1.b** Psychosocial counseling is provided with consideration to the cultural, language, educational/literacy, and accessibility needs of the participant. **9.1.c** Psychosocial counseling services include screening, psychosocial assessment, planning, counseling intervention based on a counseling service plan, and follow-up. **9.1.d** The number of psychosocial counseling sessions will be based upon the results of the psychosocial assessment. The psychosocial assessment is documented on the Psychosocial Assessment Form DH 3164 or similar format approved by the coalition. If ongoing psychosocial counseling is deemed necessary, the participant should be leveled at a 3 until it is confirmed that the participant is receiving services and the counselor reports progress in treatment is being made. **9.1.e** Psychosocial counseling services continue until identified goals are met, the participant declines services, or the participant is referred to community providers due to limited resources or need for more specialized services.

	Standards & Criteria
Chapter 9: Healthy Start Services Psychosocial Counseling (Cont.)	**Standard 9.2 The provider of psychosocial counseling will provide follow-up to the Healthy Start care coordinator.** *Criterion:* Written follow-up documenting initiated contact with the participant and plan for initiation of services is provided to the Healthy Start care coordinator within 30 days. For participants receiving on-going psychosocial counseling, communication between the provider and the Healthy Start care coordinator should occur on a monthly basis, at a minimum, in order to determine treatment progress and need for continuing service. Progress toward counseling service plan goals is documented in the participant's record. **Standard 9.3 Providers of psychosocial counseling will offer and initiate services in a timely manner.** *Criterion:* Providers of psychosocial counseling will contact participants within 10 days or less after receipt of referral or identified need to schedule an appointment for a psychosocial assessment unless the need for more immediate initiation of services is evident. **Standard 9.4 Providers of psychosocial counseling will respond to any additional identified needs.** *Criteria:* **9.4.a** Additional identified needs are addressed directly by the provider or by notifying the participant's Healthy Start care coordinator. **9.4.b** Psychosocial counseling providers communicate with the care coordinator who develops the family support plan and will collaborate as a part of the interdisciplinary team as indicated by individual need. **Standard 9.5 Providers of Healthy Start-funded psychosocial counseling will accurately code service information in a timely manner for Health Management System (HMS) data entry.**

	Standards & Criteria
Chapter 9: Healthy Start Services Psychosocial Counseling (Cont.)	*Criterion:* Coding complies with the requirements of the Department of Health publication DHP 50-20. **Standard 9.6 Providers of psychosocial counseling will document services in the participant's existing clinical record or, in the absence of a clinical record, in a format determined by the local coalition and provider.** *Criteria:* **9.6.a** Documentation of services is recorded in the record of the individual receiving services. In the event that services are provided to another household/family member, the services are only referenced in the Healthy Start program participant's record (the actual documentation occurs in the recipient's record). **9.6.b** Documentation occurs in other components of the record such as the problem list, psychosocial assessment, or family support plan and family support plan update as appropriate. **Standard 9.7 Psychosocial counseling providers will develop and implement an internal quality management (QM) and program improvement (PI) process.** *Criterion:* The QM/PI process is developed in concert with the local Healthy Start coalition and includes an assessment of strengths and areas needing improvement, and a plan for assuring maintenance of quality and program improvement. **Standard 9.8 Psychosocial counseling will be provided by qualified and trained providers.** *Criteria:* **9.8.a** Qualifications are met as outlined in this chapter and in rule 64F-3.006(5), F.A.C.

	Standards & Criteria
Chapter 9: Healthy Start Services Psychosocial Counseling (Cont.)	**9.8.b** The delivery of highly skilled activities, such as ongoing psychotherapy, counseling groups, and consultation is provided by individuals licensed or approved to provide these services by the Florida Department of Health, Medical Quality Assurance licensing boards. **9.8.c** Competency and up-to-date knowledge related to psychosocial counseling is maintained.
Chapter 10: Healthy Start Services Tobacco Education and Cessation	**Standard 10.1 All providers receiving Healthy Start funding to provide prenatal care will ask about tobacco use, advise to quit, assist in quit attempt, arrange follow-up, and advise about the dangers of ETS to the pregnant woman, those in her home, and to infants.** **Standard 10.2 Pregnant women who smoke or use other forms of tobacco will be enrolled in Healthy Start and will receive tobacco cessation services. The services will also be offered to smokers in the home.** *Criteria:* **10.2.a** The participant's record reflects documentation of enrollment in Healthy Start care coordination, tobacco cessation services, or attempts to engage the woman who smokes or smokers in the home in tobacco cessation services. **10.2.b** Level of service is based upon local resources, local Healthy Start coalition funding decisions, and consideration of Healthy Start as the payer of last resort. **10.2.c** Tobacco education and cessation services are offered to all participants' family members or household members. **10.2.d** Tobacco education and cessation services are provided with consideration to the cultural, language, educational/literacy, and accessibility needs of the participant. **10.2.e** A tobacco service that can be coded is defined as all significant interventions that educate about the dangers of tobacco use and ETS when the provider meets the provider qualifications listed in the Provider Qualifications section of this chapter.

	Standards & Criteria
Chapter 10: Healthy Start Services Tobacco Education and Cessation (Cont.)	**Standard 10.3 The Healthy Start participant's stage of readiness for change (based on Prochaska and DiClemente's Stages of Change Model) will be reviewed during each tobacco cessation service in order to offer the appropriate service.** *Criterion:* The stage of readiness for change will be assessed and used to determine and document service delivery. "Make Yours a Fresh Start Family" uses an adaptation of this model and works well for the purpose of assessing readiness for change. 1. Pre-contemplation — *provided during care coordination* 2. Contemplation — *provided during care coordination or during tobacco cessation counseling* 3. Preparation — *provided during tobacco cessation counseling* 4. Action — *provided during tobacco cessation counseling (may be used for individual or class)* 5. Maintenance — *provided during smoking cessation counseling* 6. Relapse — *provided during smoking cessation counseling*

	Standards & Criteria
Chapter 10: Healthy Start Services Tobacco Education and Cessation (Cont.)	**Standard 10.4 The provider of tobacco cessation services will provide follow-up to the Healthy Start care coordinator.** *Criterion:* Written follow-up documenting receipt of referral, plan for initiation of services, and progress notes are provided to the Healthy Start care coordinator within 30 days of the service. **Standard 10.5 Providers of tobacco cessation services will offer and initiate services in a timely manner.** *Criterion:* Tobacco cessation services are initiated within 30 days of referral or within a time frame negotiated between the provider and the coalition. **Standard 10.6 Nicotine replacement therapy (NRT) (available to non Medicaid participants through the DOH central pharmacy or to Medicaid eligible participants who are no longer eligible for reimbursement for NRT or tobacco cessation medication) and pharmaceutical aids (available through Medicaid) may be prescribed or offered for any family or household member when deemed an appropriate intervention. (People getting counseling from the Florida Quit-For-Life Line toll-free at 877-U CAN NOW get coupons for reduced costs of NRT.)** *Criteria:* **10.6a** Use of pharmaceutical aids obtained through the DOH central pharmacy requires a minimum of five sessions (six to eight are recommended). **10.6.b** Classes or groups are at least one hour in length. **10.6.c** Individual sessions are a minimum of 15 minutes.

	Standards & Criteria
Chapter 10: Healthy Start Services Tobacco Education and Cessation (Cont.)	**10.6.d** Minimum components of counseling when pharmaceutical aids are used include: 1) Consequences of tobacco use including ETS 2) Education about nicotine addiction 3) Nicotine replacement therapy (NRT) instruction 4) Review of reasons for quitting 5) Awareness of habits associated with tobacco use 6) Stress reduction methods, including deep breathing techniques 7) Exercise and nutrition 8) Relapse and relapse prevention 9) Information related to how anti-depressants designed for smoking cessation can assist a non-pregnant, non-breastfeeding mother of a Healthy Start infant 10) Information on the possibility of continuing breastfeeding when using NRT 11) Advice to smokers who breastfeed and do not want to quit that smoking just before or during breastfeeding should be avoided 12) Appropriate method for disposal of patches 13) Danger of smoking while wearing the patch 14) Side effects and contraindications listed in the corresponding prescribing information of the transdermal nicotine patch prescribed **Standard 10.7 Providers of tobacco cessation services will respond to any additional identified needs.** *Criteria:* **10.7.a** Additional identified needs are addressed directly by the provider or by notifying the participant's Healthy Start care coordinator. **10.7.b** Tobacco cessation providers communicate with the care coordinator who develops the family support plan and collaborates as a part of the interdisciplinary team as indicated by individual need. **Standard 10.8 Providers of Healthy Start funded tobacco education and cessation services will accurately code service information in a timely manner for Health Management System (HMS) data entry.**

	Standards & Criteria
Chapter 10: Healthy Start Services Tobacco Education and Cessation (Cont.)	**Standard 10.9 Providers of tobacco education and cessation services will document services in the participant's existing clinical record or, in the absence of a clinical record, in a format determined by the local coalition and provider.** *Criteria:* **10.9.a** Documentation of services is recorded in the record of the individual receiving services. In the event that services are provided on behalf of a participant, the services are only referenced in the Healthy Start program participant's record (the actual documentation occurs in the recipient's record). **10.9b** Documentation occurs in other components of the record such as the problem list and family support plan as appropriate. **10.9c** Documentation includes reference to the assessment process and indicates participant's stage of change, i.e. pre-contemplation, contemplation, etc. Progress and plans made during the service are documented. **10.9.d** Documentation shows that even if a participant shows low interest in quitting tobacco, the service is offered appropriate for the stage of change at each contact. **Standard 10.10 Tobacco cessation service providers will develop and implement an internal quality management (QM) and program improvement (PI) process.** *Criterion:* The QM/PI process is developed in concert with the local Healthy Start coalition and includes an assessment of strengths and areas needing improvement and a plan for assuring maintenance of quality and program improvement. **Standard 10.11 Tobacco education and cessation services will be provided by qualified and trained providers.** *Criteria:* **10.11.a** Qualifications are met as outlined in this chapter and as specified in rule 64F-3.006(6), F.A.C. https://www.flrules.org/gateway/readFile.asp?sid=0&tid=2575949&type=1&file=64F-3.006.doc

	Standards & Criteria
Chapter 10: Healthy Start Services Tobacco Education and Cessation (Cont.)	**10.11.b** Competency and up-to-date knowledge related to tobacco education and cessation services is maintained.
Chapter 11: Home Visiting and Other Variations in Service Delivery Sites	**Standard 11.1 Healthy Start services will be participant and family focused and provided at sites where the concerns, priorities, and resources of the participant and/or family can best be met in a cost-effective manner.** *Criterion:* The Healthy Start participant receives services in the home or in varied service delivery sites based upon identified level of risk, need, and participant's ability to access services. **Standard 11.2 Healthy Start services delivered in the home or in varied service delivery sites will be provided by qualified and trained providers.** *Criteria:* **11.2.a** Qualifications and competencies are met as specified in Chapters 4 –10, 20, and 21 of these Standards and Guidelines, and as specified in rule 64F-3.006(8), F.A.C. **11.2.b** All providers of services delivered in the home or in varied service delivery sites receive a minimum of two weeks pre-service training or demonstrate competencies as specified in Chapters 4 -10, 20, and 21 of these Standards and Guidelines, as appropriate. Training should be divided into two tracks; professional and paraprofessional. Pre-service training related to home visiting should include both formalized training with a structured curriculum and opportunities for the trainee to accompany an experienced home visitor as he/she performs home visits. A curriculum for training related to home visiting should include, at a minimum, the following elements: • Information on the potential benefits of home visiting; • Information on some of the drawbacks of home visiting; • Discussion on being a guest in a participant's home;

	Standards & Criteria
Chapter 11: Home Visiting and Other Variations in Service Delivery Sites (Cont.)	• Discussion regarding how home visiting can complement other modes of Healthy Start service delivery; • Discussion regarding how to decide which clients will benefit most from home visiting; • Training regarding HMS coding for home visiting; • Training regarding whichever questionnaires/screening tools have been adapted by the local Healthy Start services provider (e.g. Denver II, Ages and Stages, etc.); • Information on safety concerns related to home visiting and how to minimize associated risks; • Information regarding cultural differences, respect for the values and beliefs of people of many different cultures, and the ability to respond appropriately and sensitively. **11.2.c** Competency and up-to-date knowledge related to home visiting and community-based service delivery is maintained. **11.2.d** Training materials that are provided by the Department of Health and locally adapted resources are utilized. **11.2.e** All providers participate in pre-service and ongoing locally provided training. **Standard 11.3 All providers of home visiting services or services in varied service delivery sites will accurately code service information in a timely manner for Health Management System (HMS) data entry.** *Criterion:* Coding complies with the requirements of the Department of Health publication DHP 50-20. All home visiting services or services delivered in varied service delivery sites will be coded to the appropriate service location. **Standard 11.4 Providers of services in the home or in varied service delivery sites will document services in the participant's existing clinical record, or in the absence of a clinical record, in a format determined by the local coalition and provider.**

	Standards & Criteria
Chapter 11: Home Visiting and Other Variations in Service Delivery Sites (Cont.)	*Criteria:* **11.4.a** Services are documented in the record of the individual receiving the services. In the event that services are provided to another person on behalf of a Healthy Start program participant, the services are only referenced in the Healthy Start participant's record. The actual detailed documentation occurs in the record of the individual receiving the service. **11.4.b** Documentation occurs in other components of the record, such as the Problem List or Family Support Plan (DH 3151), as appropriate. **11.4.c** An authorization for release of information is requested from every participant receiving a face-to-face contact. If the release is refused, the refusal is documented in the participant's record. If the release is obtained, the original form is maintained in the participant's record. **11.4.d** Documentation of services includes, at a minimum, documentation of: 1. All attempts, successful or unsuccessful, to provide service in the home or in varied service delivery sites to potential program participants, and *2.* All activities and components of care coordination and Healthy Start services provided as outlined in these Standards & Guidelines.
Chapter 12: Substance Abusing Pregnant Women, Substance Exposed Children, and Their Families	**Standard 12.2 All prenatal care providers receiving Healthy Start funding to provide prenatal care will educate women about the dangers of using alcohol or other drugs, conduct verbal screening for substance abuse, and refer for substance abuse treatment when substance abuse is identified.** Criterion: Prenatal care provider's records reflect documentation of education about the dangers of substance abuse during pregnancy, verbal screening for substance abuse, and appropriate referrals and interventions. Drug toxicologies may be done at the provider's discretion with the client's informed consent.

	Standards & Criteria
Chapter 12: Substance Abusing Pregnant Women, Substance Exposed Children, and Their Families (Cont.)	**Standard 12.3 Pregnant substance abusing women will be enrolled in Healthy Start care coordination services.** Criteria: **12.3.a** The participant's record reflects documentation of enrollment in Healthy Start care coordination or persistent attempts to engage the woman in Healthy Start. Note: A pregnant substance abusing woman is to be considered as a care coordination level three until information received indicates otherwise. **12.3b** Once the participant is receiving Healthy Start care coordination, the participant's record reflects documentation of the following: • Education about effects of alcohol and other drug abuse on mother and infant; • Verification whether the woman is or is not getting drug treatment or referral to drug treatment and follow-up; • Assessment of progress towards abstinence at each visit, provision of support and referrals as appropriate; • Discussion of future family planning steps and referral for family planning if desired; • Assessment of adequacy of the physical home environment for mother and the new baby; • Identification of services needed, referrals for needed services, and follow up on referrals to assess outcome and need for further assistance in linking with needed service; • Ongoing assessment of the safety, health, and developmental status of children in the home and educating the mother and caregiver about ways to promote child health, safety, and development; • Progress on or a completed Family Support Plan; • Ongoing coordination with other service providers. **Standard 12.4 The county health department is notified by hospitals and other birthing facilities of all infants prenatally exposed to abuse of prescription and non-prescription drugs.** *Criterion:* The coalitions will ensure hospital and other birthing facility staff are aware of the responsibility in accordance with s. 383.14, F.S. to identify and refer for Healthy Start services all infants prenatally exposed to abuse of prescription drugs and illegal substances.

	Standards & Criteria
Chapter 12: Substance Abusing Pregnant Women, Substance Exposed Children, and Their Families (Cont.)	**Standard 12.5 The Healthy Start care coordinators report pregnant substance abusing women and infants prenatally exposed to illegal drugs to the Department of Health.** *Criterion:* The Healthy Start care coordinator documents services to women who have abused illegal drugs during pregnancy and services to children prenatally exposed to illegal drugs by coding 2 in field 19 of the Healthy Start Encounter Form. **Note:** For providers using the HMS, this substance abusing pregnant women or substance exposed infants information must be entered into the system under the "Extended Demographics" tab. **Standard 12.6 All substance exposed children will receive Healthy Start care coordination whether or not the child received a positive score on the Healthy Start infant (postnatal) risk screen or was reported to Florida's Abuse Hotline. If the current caregiver is not the biological mother, the caregiver has the authority to consent to Healthy Start participation.** *Criteria:* **12.6.a** The participant's record reflects documentation of Healthy Start care coordination services or documents inability to provide them including: • Referral of infant for Healthy Start care coordination services; • Enrollment in Healthy Start care coordination; **Note:** A substance exposed child is to be considered as a care coordination level three until information received indicates otherwise. **Standard 12.7 A home assessment will be completed prior to hospital discharge of a substance exposed newborn, or the record will show why the assessment was not completed at that time.**

Chapter 12: Substance Abusing Pregnant Women, Substance Exposed Children, and Their Families (Cont.)	*Criteria:* **12.7.a** The participant's record reflects documentation of a comprehensive home assessment and provision of parenting support services, including the following items: • A meeting with the birth mother and any other intended caregiver, if the mother will not be the primary caregiver, and a visit to the home of the mother/caregiver; • An environmental and family assessment focused on the safety and quality of care that is or will be provided for the child, including: a) Health condition of the child; b) The mother and any other caregiver's ability to care for the child's unique needs in the home environment; c) Strengths and needs relating to family composition including dissentions in the family that may affect the child; d) Parenting capabilities of those persons in the home with primary child care responsibilities; e) The adequacy of the physical environment of the home; f) Identification of services needed; g) Education needs of the mother and caregiver for any special health-related care the child may require; h) Identification of the strengths of the mother, infant, and others in the home. • Identifying and responding to immediate family needs; • Parent education, information, and anticipatory guidance about normal growth and development, effects of prenatal and postnatal substance exposure, child soothing techniques, and feedback about mother /caregiver child interaction; • Reinforcing previous information given about the effects of alcohol, tobacco, and other drugs; • Comprehensive health care service provision for the child, and for other children in the home, according to the Medicaid Child Health Check Up periodicity schedule; • Referral for early intervention assessment or Children's Medical Services when the need for further developmental assessment or services are indicated; • Verification that the mother is getting drug treatment or referral to drug treatment and follow-up; • Support of the mother's steps towards substance abuse abstinence including encouraging her to comply with substance abuse treatment, and explaining the consequences of failure to comply with substance abuse treatment, the family support plan, or protective supervision case plan; • Crisis intervention as appropriate; • Provision of feedback to other service providers; • Initiation of a family support plan with the family and other participating service providers; • Referral to needed services. **Standards & Criteria**

Chapter 12: Substance Abusing Pregnant Women, Substance Exposed Children, and Their Families (Cont.)	**12.7.b** Documentation reflects a home visit within three days of referral of a substance exposed newborn in the event a pre-discharge visit is not possible due to brevity of hospital stay, failure to be notified of infant prior to discharge, attempted contacts, inability to locate, or other reasons for failure to comply with the standard criterion. **Standard 12.8 An infant and home assessment will be conducted after the care coordination provider is notified of the infant's discharge from the hospital.** Criteria: **12.8.a** The participant's record reflects documentation of an infant and home assessment within three days of notification of the infant's discharge. If a prior home and family assessment was conducted within the last month and satisfactory conditions were found, then the three-day requirement is extended to five days. **12.8.b** The participant's record reflects documentation of the post-discharge home assessment including those areas listed in Standard 12.7.a or attempted contacts, inability to locate, or other reasons for failure to comply with the standard criterion are documented. **Standard 12.9 If the Department of Children and Families is providing services to the family, a report of the results from both the pre-discharge and the post-discharge infant and home assessments will be received by the local Department of Children and Families designated protective investigator within 72 hours of the assessment. (The report is submitted sooner when the child's health or safety requires.)** *Criterion:* The participant record reflects: • Name of Family Safety designated protective investigator(s) working with family; • Submission of a verbal or written report within 72 hours (the written report may be submitted by facsimile (Fax) when confidentiality of information is assured); • Submission of the original written report; • Pertinent findings incorporated into the existing or evolving family support plan.
	Standards & Criteria

Chapter 12: Substance Abusing Pregnant Women, Substance Exposed Children, and Their Families (Cont.)	**Standard 12.10 Ongoing care coordination and infant and home assessments will be provided at an intensity and duration commensurate with the level of risk to the child and with the mother's needs.** *Criterion:* The participant's record reflects documentation of care coordination services and home assessments addressing items in standard 12.7 and consistent with Chapter 4, Care Coordination and Risk Appropriate Care, or the record documents the inability to provide these services. **Standard 12.11 Any time the infant or home assessment reveals that the mother or caregiver is not able to care for the child, a report will be made to the Abuse Hotline by calling 1-800-96 ABUSE.** *Criteria:* **12.11. a** The record reflects that the Healthy Start care coordinator reported the child to the abuse hotline if 1) the provider felt that the mother or caregiver was unable to care for the child, or 2) there was concern about neglect or abuse. **12.11.b** Documentation of report and rationale for the report is present in the infant's record. **Standard 12.12 Care coordination services will be provided for the birth mother, regardless of whether the mother has or will retain custody of her child. Appropriate services will also be offered to the caregiver when the mother is not the primary caregiver.** *Criterion:* The following services are documented in the record as specified: • Ongoing assessment of mother's postpartum recovery, ongoing health and family planning needs, and progress towards recovery from substance abuse (mother's record); • Ongoing care coordination with the mother and the infant including intervention, referrals, follow-up, and liaison with other agencies (respective records); • Ongoing assessment of safety, health, and developmental status of the infant and other children in the home (respective records); • Coordination and assurance of primary health care services for the mother, and for the infant according to the Child Health Check-Up periodicity schedule (respective records); **Standards & Criteria**

Chapter 12: Substance Abusing Pregnant Women, Substance Exposed Children, and Their Families (Cont.)	• Counseling of the mother and encouragement to comply with substance abuse treatment, to include an explanation of the consequences for failure to comply with substance abuse treatment, the family support plan, a performance agreement, or protective supervision case plan (mother's record); • Providing or referring the mother for parenting education, information and anticipatory guidance about normal growth and development, effects of substance exposure, child soothing techniques, also noting and providing feedback about mother/caregiver child interaction (mother's record documents referrals made, services received, efforts made to remove any barriers to getting needed services); • Providing or referring for crisis intervention; • Conducting the necessary home visits or other visits necessary to provide the services listed above; • Providing feedback to other service providers working with the family; • Follow up on recommendations. **Standard 12.13 Transition of care coordination to the county health department will occur after eligibility for Healthy Start ends.** *Criterion:* The transition will be made or inability to do so is documented. Transition procedures include: • Discussion with the family; • Assurance of participant's signature on a consent to release information form; • Notification of the appropriate county health department staff of the impending transfer of care coordination; • Update of the family support plan with the infant's family/caregiver, other service providers, and county health department care coordinator; • Transfer of all care coordination records to the county health department. **Standards & Criteria**

Chapter 12: Substance Abusing Pregnant Women, Substance Exposed Children, and Their Families (Cont.)	**Standard 12.14 Care coordination case closure for substance exposed children is at age 3.** *Criterion:* Because of the nature of substance abuse addiction and the possibility of relapse, care coordination of substance exposed children usually continues until the child is three. At times, there are unusual circumstances which warrant an earlier termination of services. Documentation reflects justification for termination of services, including the following: • Care coordination services are stopped following consultation with the supervisor and when one of the following occurs: a) The environment is assessed to be reasonably safe for the child with low risk of danger or harm to the child; or b) A permanent or long-term placement for the child has been established separate from the biological mother's or substance abusing parent's home; the permanent or long-term family has been educated about the child's special needs and no longer desire care coordination services; and the biological mother no longer can benefit from services; or c) The mother/caregiver with whom the child is living refuses services and there is no court-ordered supervision of the child or family (services may be re-offered at a later time); or d) Persistent attempts to locate have failed. • Information is left with the family describing the process for reinitiating services should the family determine a need later. • Other service providers are notified prior to care coordination closure as appropriate.
Chapter 13: Transition and Interagency Agreements	**Standard 13.1 The Healthy Start Coalition will assure a seamless transition of care for pregnant/interconception women and infants/children within their community through the development of interagency agreements.** *Criteria:* **13.1.a** Healthy Start coalitions and care coordination providers have formal written agreements with programs with which they share mutual clients. At a minimum, interagency agreements should be developed with the following: • Early Steps, Children's Medical Services; • Neonatal Intensive Care Units for NICU clients; • Regional Perinatal Intensive Care Centers (RPICCs) and other Level III Centers; **Standards & Criteria**

Chapter 13: Transition and Interagency Agreements (Cont.)	• Children's Medical Services for Children with Special Health Care Needs; • Department of Children and Families for pregnant, substance abusing women and substance exposed children; • County health departments in the event the county health department is not the sole provider of care coordination; • Healthy Families Florida projects; • Lead care coordination agency changes from one provider to another provider. **13.1.b** Comprehensive written agreements between agencies and programs contain the following elements: • Purpose of the agreement; • Description of agencies involved in the agreement, including agency roles and responsibilities; • Requirements impacting the agreement, as appropriate; • Definition of terms pertinent to the agreement; • Working procedures and timelines; • Implementation plan for the agreement; • Monitoring and evaluation of the agreement; • Interagency dispute process; • Duration of the agreement; • Signatures and dates.
Chapter 14: Healthy Start Coding	**Standard 14.1 Every Healthy Start participant will be registered into the Health Management System (HMS).** *Criterion:* Registration complies with the requirements of the Department of Health publication DHP 50-20. **Standards & Criteria**

Chapter 14: Healthy Start Coding (Cont.)	**Standard 14.2 Providers of Healthy Start funded services will accurately code service information in a timely manner.** *Criterion:* Service information coding complies with the requirements of the Department of Health publication DHP 50-20. **Standard 14.3 Providers of services funded by Healthy Start will enter, or forward for entry, accurate service information in the HMS in a timely manner.** *Criterion:* Coalition assures adequate staffing and resources necessary to support and maintain the data entry system in county health departments. **Note:** The department is in a transitional phase to eliminate the use of encounter forms. All providers are not currently rolled out to HMS; therefore, references to encounter forms pertain only to those providers that have not begun to use HMS. **Standard 14.4 Healthy Start service providers will develop and implement an internal quality management and program improvement process for HMS coding.** *Criterion:* The QM/PI process is developed in concert with the local Healthy Start coalition and includes an assessment of strengths, areas needing improvement, and a plan for quality management and program improvement.
Chapter 15: Healthy Start System Assurances	**Standard 15.1 A coordinated, comprehensive Healthy Start system will be maintained in each coalition's area, as resources allow.** *Criteria:* **15.1.a** A data-driven and evidence-based service delivery plan is developed and updated by the Healthy Start coalition at least every five years that includes a comprehensive assessment of maternal and child **Standards & Criteria**

Chapter 15: Healthy Start System Assurances (Cont.)	health indicators, prenatal and infant health care services, Healthy Start activities and services (as listed in 15.5 below), identification of service gaps and needs, local funding priorities, and a quality management and program improvement strategy. The service delivery plan shall provide the basis for contracting with local Healthy Start providers. **15.1.b** All activities and services provided under contract/memorandum of agreement with any Healthy Start provider are delivered in accordance with the standards described in Healthy Start Standards & Guidelines. **15.1.c** All applicable Healthy Start services standards are specified in the contracts/memoranda of agreement between the coalition and Healthy Start providers. **15.1.d** A network of providers offering Healthy Start prenatal and infant risk screening is established and maintained as described in Chapter 3, Risk Screening. This includes designation of responsibility for training of prenatal care providers and birth facility staff who are responsible for the provision of Healthy Start screening. **15.1.e** Community education and public awareness activities are conducted to inform the community about the Healthy Start system, its services, target populations, and accomplishments. **15.1.f** An annual action plan update is developed, approved by the coalition, and disseminated to the community and the Department of Health regarding the Healthy Start system and services, which indicates the status of the service delivery plan and documentation of progress toward achievement of coalition goals. **15.1.g** All activities and services are provided with sensitivity to cultural, language, educational, and accessibility needs. **Standard 15.2 All Healthy Start providers and administrators will be adequately trained and prepared to fulfill their responsibilities related to Healthy Start.** **Standards & Criteria**

Chapter 15: Healthy Start System Assurances (Cont.)	Criteria: **15.2.a** Qualifications as outlined in these Standards & Guidelines and as specified in rule 64F-3.006(4), F.A.C. **15.2.b** Competency and up-to-date knowledge are maintained including the utilization of training and technical assistance provided by the Department of Health. **15.2.c** Training materials provided by the Department of Health and locally adapted resources are used. **15.2.d** Pre-service and ongoing training is provided locally. **Standard 15.3 The Healthy Start screening infrastructure will be maintained.** *Criterion:* Adequate staff and resources to comply with the standards as described Chapter 3, Risk Screening, and in rules 64F-3.002 (1) through (6) F.A.C. are maintained. **Standard 15.4 Quality data will be generated from all Healthy Start providers at the local level for Healthy Start screening and services funded by Healthy Start**. Criteria: **15.4.a** Completeness and accuracy of screening instruments are maintained. **15.4.b** Healthy Start screening reports are reconciled with local program/participant information. **15.4.c** Completeness, timeliness, and accuracy of HMS coding of service data are ensured. **15.4.d** Completeness, timeliness, and accuracy of data entry are ensured. **15.4.e** State service data reports are reviewed to identify and resolve discrepancies. **15.4.f** Needed training is requested and provided in a timely manner.

	Standards & Criteria
Chapter 15: Healthy Start System Assurances (Cont.)	**Standard 15.5 Allocation of Healthy Start service delivery funds will be prioritized and based on community need service delivery planning and decision making at the coalition level.** *Criterion:* These are the range of services that may be provided using Healthy Start funds based on the service delivery plan and community needs: • Outreach to identify potential participants and assure access to prenatal and child health care; • Outreach to providers to ensure provision of care to the uninsured; • Provision of prenatal care for all pregnant women with assurance that all other community or insurance resources have been exhausted; • Prenatal Care Supportive Services that include PEPW determination, SOBRA enrollment, case management, and outreach such as: a) Provider education and distribution of the simplified application for pregnant women eligible for SOBRA Medicaid coverage; b) Organization and implementation of a SOBRA prenatal care counseling and care management system either directly or through contract with a qualified agency; c) Hospital visits to follow up on births of babies to help identify potential participants and enhance family planning and well baby checks; d) Community visits to locations frequented by women of childbearing age who may be pregnant but unable to access care (e.g. migrant neighborhoods, community centers); e) Community education activities as outlined in the Healthy Start Standards & Guidelines; f) Free pregnancy testing and information, referral and assurance that pregnant women get into prenatal care and non-pregnant women get into family planning if needed. g) Development and maintenance of a screening infrastructure, including educating providers of the requirement to screen. h) Implementation of risk appropriate care based on levels of care and intensity of services included in the Medicaid Waiver;

	Standards & Criteria
Chapter 15: Healthy Start System Assurances (Cont.)	• Comprehensive care coordination including: a) Initial contact; b) Initial assessment; c) Ongoing care coordination; d) Other Healthy Start services based on the community needs assessment (including Fetal and Infant Mortality Review findings, where available); e) Childbirth education; f) Parenting; g) Tobacco cessation education; h) Nutrition counseling; i) Psychosocial counseling; j) Breastfeeding education and support; k) Interconception education and counseling; l) Other family supportive services based on the needs assessment and service delivery plan after the above have been adequately assured. **Standard 15.6 Prioritization of service delivery will be evident in the local Healthy Start system.** *Criterion:* Prioritization requirements are reflected in the coalition service delivery plan and contracts/memoranda of agreements. Service prioritization and identified target population are based upon: • Assessment of maternal and child health indicators, risk factors, and need within the service delivery area; • Consideration of public health priority populations such as substance abusing pregnant women, substance exposed children, and HIV and/or Hepatitis B positive mothers and children; • Availability of other community resources to offset the risks and needs; • Services corresponding to identified risk factors that are likely to have a positive impact on targeted outcome indicators.

	Standards & Criteria
Chapter 15: Healthy Start System Assurances (Cont.)	**Standard 15.7 All Healthy Start providers will account for the use of the Healthy Start funds that are awarded to them.** *Criteria:* **15.7.a** Providers maintain ledgers, records, and documents that sufficiently and accurately reflect all expenditures of Healthy Start funds. **15.7.b** Providers submit expenditure reports to the coalition at a minimum annually, or as specified under contract. **Standard 15.8 An ongoing quality management and program improvement mechanism for the delivery of Healthy Start services and maintenance of the Healthy Start system will be implemented.** *Criteria*: **15.8.a** Each Healthy Start coalition and provider has an ongoing quality management and program improvement system in accordance with the standards listed in Chapter 17, "Quality Management/Program Improvement (QM/PI) for Healthy Start Providers and Coalitions." **15.8.b** Coalitions monitor the provision of Healthy Start services through the review of provider reports and on-site visits, including a review of participant records, at least annually and more frequently if needed. **15.8.c** Coalitions assure Healthy Start services are provided according to the local service delivery plan, written agreements between the Department of Health and the Department of Children and Families, and chapters 64F-2 , and 64F-3, Florida Administrative Code. **15.8.d** Coalitions provide feedback (on outcome of the quality management/program improvement process, including the development and implementation of a performance improvement plan when appropriate) to the coalition board of directors, Healthy Start providers, and providers of Healthy Start screening. **15.8.e** Coalitions assure that information from the quality management/program improvement process is used in the planning and decision-making for annual action plan updates and service delivery plan updates.

	Standards & Criteria
Chapter 15: Healthy Start System Assurances (Cont.)	**15.8.f** Coalitions may complete a self-assessment using the Healthy Start Coalition Assessment Tool (see Appendix G) to identify strengths, weaknesses, and potential areas for improvement as part of their service delivery plan update. **Standard 15.9 Providers of services funded by Healthy Start will collect and enter or forward for entry accurate service information for the Health Management System (HMS) in a timely manner.** *Criteria:* **15.9.a** Coding complies with the requirements of the Department of Health publication DHP 50-20. **15.9.b** The Healthy Start Coalition assures adequate staffing and resources necessary to support and maintain the data entry system in county health departments. **Standard 15.10 Collaborative working relationships and agreements among community service providers will be developed and maintained.** *Criteria:* **15.10.a** Activities among community providers serving Healthy Start participants including joint projects, collaborative funding, meetings, etc. are documented. **15.10.b** Written agreements are developed to include, at a minimum, agreements with the following: • Children's Medical Services Early Steps; • Neonatal Intensive Care Units (NICUs); • Children's Medical Services Regional Perinatal Intensive Care Centers (RPICCs) for high risk pregnant women; • Children's Medical Services for Children with Special Health Care Needs; • The Department of Children and Families for pregnant substance abusing women and substance exposed children; • County health departments in the event the county health department is not the sole provider of care coordination; and • Healthy Families Florida Program for families at risk of child abuse and neglect.

	Standards & Criteria
Chapter 16: Performance Based Contracts and Memoranda of Agreement	**Standard 16.1 All Healthy Start direct services dollars allocated through the Healthy Start coalitions will be dispensed through contracts or memoranda of agreement.** *Criteria:* **16.1.a** All contracts and/or memoranda of agreement entered into between the Healthy Start coalition and providers of direct Healthy Start participant services will contain the specified elements of a performance based contract as described in the Contract Management System for Contractual Services (75AMP2), Section VII.B. **16.1.b** The agreed upon performance measures between the Department of Health and the Healthy Start coalition will be incorporated, when appropriate, into contracts and/or memoranda of agreement the coalition enters into with providers of direct Healthy Start participant services. **16.1.c** All services purchased through contracts and/or memoranda of agreement will meet the requirements of legislative intent and Department of Health policy and will be provided in accordance with the standards contained in the Healthy Start Standards and Guidelines. **16.1.d** All contracts and/or memoranda of agreement entered between the Healthy Start coalition and providers of direct Healthy Start participant services will, within 30 days of execution, be submitted to the Department of Health and reviewed for required contract and service elements and quality standards.
Chapter 17: Quality Management/Program Improvement (QM/PI) for Healthy Start Providers and Coalitions	**Standard 17.1 A written QM/PI process will be implemented by all Healthy Start providers.** *Criterion:* The process must designate the frequency that reviews will be conducted and the data components that will be reviewed. The provider will use the designated data components to analyze and document program strengths and weaknesses and to identify areas for both quality maintenance and program improvement.

Topic	
Chapter 17: Quality Management/Program Improvement (QM/PI) for Healthy Start Providers and Coalitions (Cont.)	**Standard 17.2. All contracts executed by Healthy Start coalitions for Healthy Start services will include a statewide core set of outcome and performance measures based on the current Healthy Start Standards and Guidelines. Coalitions and their subcontracted providers shall incorporate at a minimum the applicable core outcome and performance measures for the contracted services. Additional outcome and performance measures may be negotiated between the provider and the local Healthy Start coalition and included in the contract.** *Criteria:* **17.2.a** Measurement, tracking, and analysis of core outcome and negotiated performance measures will guide providers and coalitions in the development of service delivery plans that address areas for program maintenance and improvement. This analysis should be completed at least quarterly. **17.2.b** Each performance measure should include baseline data when available and a specific goal measurement to be achieved and maintained. **Standard 17.3 A Performance Improvement Plan (PIP) will be developed by the provider and approved by the local Healthy Start coalition, or initiated by the coalition based on review of quarterly deliverables in the event that core outcome or negotiated performance measures are not being met.** *Criteria*: **17.3.a** The PIP is ideally developed by the provider and submitted to the local Healthy Start coalition. If the provider does not develop a plan, the coalition will initiate the PIP. The coalition will review the submitted PIP and either approve the plan as written or return the plan to the provider with feedback for further revisions. **17.3.b** The plan must delineate services and processes that should be maintained and those that need improvement. For services or processes that are not meeting the established performance standards, the plan should define strategies and process changes designed to directly improve performance outcomes. **17.3.c** The coalition will provide the Department a copy of the approved PIP in the quarterly deliverables to the Department.

	Standards & Criteria
Chapter 17: Quality Management/Program Improvement (QM/PI) for Healthy Start Providers and Coalitions (Cont.)	**Standard 17.4 The PIP will be updated quarterly and submitted to the coalition for approval or further revision. The coalition will submit a copy of the approved, updated PIP to the Department as part of the coalition's quarterly deliverables.** *Criterion:* The PIP contains at a minimum: 1) the status of performance achievement, 2) the status of progress toward full implementation of strategies and their impact on the performance outcome, and 3) discussion of additional strategies that will be attempted or of strategies found to be ineffective that will be discontinued.
Chapter 18: Fiscal Accountability	**Standard 18.1 Each Healthy Start coalition will account for the use of service dollars for administrative costs.** *Criterion:* Healthy Start coalitions can request up to 10% of their service dollar allocation for the below listed administrative functions*:* • Quality Assurance/Quality Improvement • Contract Management • Fiscal Accountability **Standard 18.2 Each Healthy Start provider will account for the use of Healthy Start funds to its local Healthy Start Coalition.** *Criterion:* All contracts and/or Memoranda of Agreement for Healthy Start funded services are in the form of performance-based agreements that: • Specify components of fiscal reporting • Specify frequency of fiscal reporting • Specify Healthy Start performance measures

	Standards & Criteria
Chapter 18: Fiscal Accountability (Cont.)	**Standard 18.3 Healthy Start funds will be used as payer of last resort.** *Criterion:* Healthy Start funds are expended only when all other community or insurance resources have been exhausted. The Healthy Start coalition and the contracted provider should negotiate a system that verifies that all payor sources, including assisting the client to apply for Medicaid, have been exhausted.
Chapter 19: Information Security Requirements	**Standard 19.1 Providers of Healthy Start services will comply with applicable Department of Health Information Security Policies, Protocols, and Procedures.** *Criteria:* **19.1.a** Healthy Start providers have written information security policies. **19.1.b** All participant-related information is retained, archived, and destroyed according to the Records Retention Schedule, Department of State, Division of Library and Information Services, Bureau of Archives and Records Management. **19.1.c** Participant-related records are maintained in designated secure areas. **19.1.d** Prudent and reasonable precautions are taken to protect confidential information. **19.1.e** Each Healthy Start contract includes standard contract language that requires the contractor to comply with current departmental information security policies, protocols, and procedures. **19.1.f** Confidential medical information is not released without proper authority. **19.1.g** Confidentiality of HIV/AIDS, STD, and TB case reports is maintained.

	Standards & Criteria
Chapter 20: SOBRA Outreach Program	**Standard 20.1 The maternity care advisor shall be responsible for attempting to contact by telephone all SOBRA eligible women identified on the weekly Medicaid fiscal agent list within five working days to:** *Criteria:* **20.1.a** Explain the program including program benefits, how to access both prenatal care and wraparound services, register grievances and answer questions, and identify if the enrollee has any special needs; **20.1.b** Present a list of prenatal care providers to enrollees who have not chosen a prenatal care provider. This list will include information compiled by the coalition about language skills and specialty areas of practitioners and their office staff; **20.1.c** Assist enrollees with their choice of prenatal care providers; **20.1.d** Register the enrollee's choice of a prenatal care provider in the SIS; **20.1.e** Facilitate the initial or next appointment with the selected provider; **20.1.f** Determine if the enrollee has completed a Healthy Start screen and, if not, facilitate the completion; **20.1.g** Determine if the enrollee is registered in the Women Infant and Children's (WIC) nutrition program and if not participating, facilitate enrollment; and **20.1.h** Inform the enrollee of her rights to change prenatal care providers and the mechanism to do so when the enrollee is notified of her prenatal care provider assignment.

	Standards & Criteria
Chapter 20: SOBRA Outreach Program (Cont.)	**Standard 20.2 Within 30 days of notification from the fiscal agent, the maternity care advisor shall register the enrollee with her selected prenatal care provider and facilitate the completion of the Healthy Start screen. The maternity care advisor shall make at least three attempts to contact within the first 30 days of notification of eligibility by the fiscal agent.** *Criterion:* The coalition receives a listing of SOBRA eligible pregnant women in the MU and MMP categories every week on Monday. The maternity care advisor has five working days to make the first attempt to contact each woman to explain the program and facilitate enrolling her choice of a prenatal care provider. Within the thirty-day period, the maternity care advisor has to make three attempts to contact before auto-enrolling an enrollee with a prenatal care provider. Of those enrollees that the maternity care advisor is unable to reach by phone within the thirty-day period, at least 25% will receive an attempted face-to-face contact. Priority will be given to enrollees who have no phone but have a street address for this attempted face-to-face contact. **Standard 20.3 If the enrollee has not made a decision within 30 days, the maternity care advisor shall assign a prenatal care provider by selecting from providers within a thirty-minute drive of the enrollee's residence. Coalitions with more than one prenatal care provider who meet this requirement shall assign a prenatal care provider to the enrollee based upon a locally-established unbiased protocol. The selection process shall be weighted for those group practices with more than one prenatal care provider.** *Criterion:* Within the thirty-day period, the maternity care advisor will either enter the enrollee's choice of a prenatal care provider into the SIS or assign a prenatal care provider based on the local protocol that is in place by the Healthy Start coalition. The local protocol must take into account the choice of providers that are within a thirty-minute drive radius of the enrollee's residence. **Standard 20.4 The maternity care advisor shall inform the recipient that her prenatal care provider can be changed for up to 60 days from provider enrollment. However, after 60 days, it is recommended that the recipient would only change providers for the following reasons:** *Criteria:* **20.4.a** Change of recipient's county of residence;

	Standards & Criteria
Chapter 20: SOBRA Outreach Program (Cont.)	**20.4.b** Cause, such as recipient's inability to schedule appointments in a timely manner with the provider, or patient/provider conflict; **20.4.c** Prenatal care provider termination from Medicaid or relocation; or **20.4.d** Recommendation of the provider based on complications of recipient's pregnancy such as to a Regional Perinatal Intensive Care Center provider. **Note:** If automatic assignment of a prenatal care physician was made by the coalition, the coalition shall recommend that the recipient not change her provider after 60 days from the date notified. **Standard 20.5 For all recipients that have been auto-assigned, (meaning they have not been verbally contacted but their provider choice has been registered), the coalition shall provide one additional attempt to communicate.** *Criterion:* **20.5.a** Communication with the recipient can be by a letter, telephone call, or a face-to-face encounter. The maternity care advisor will make this one additional attempt to communicate to women who have been auto-assigned or not verbally contacted between day 31 and the end of month 5. **Standard 20.6 The maternity care advisor shall provide follow-up services as needed to recipients. These follow-up services can include, but are not limited to, the following criteria:** *Criteria:* **20.6.a** Ensuring that the coalition's prenatal care counselors work closely with prenatal care providers for notification of no-shows or problems; **20.6.b** Contacting the recipient to determine the reasons for reported no-shows and facilitating rescheduling; **20.6.c** Assisting the recipient in accessing recommended prenatal care and WIC enrollment services and resolving problems in receipt of care;

	Standards & Criteria
Chapter 20: SOBRA Outreach Program (Cont.)	**20.6.d** Facilitating continuity of prenatal care in case of provider termination, loss of Medicaid coverage, or other problem; **20.6.e** Ensuring that the coalition's prenatal care counselors facilitate making appointments for recipients for other health services if needed; **20.6.f** Conducting periodic surveys with samples of recipients concerning their access to all services. **Standard 20.7 After enrollment, between the sixth and ninth month of her pregnancy, the coalition shall provide the three mandatory post-enrollment services to recipients, including recipients that are auto-assigned. These services shall include:** **20.7.a.** Facilitate accessing family planning services; **20.7.b.** Facilitate accessing health care coverage for the infant; **20.7.c.** Facilitate choosing a pediatric care provider for the infant. **Standard 20.8 The coalition shall work with prenatal care providers to provide them with information on the Healthy Start program available to recipients.** *Criterion:* Healthy Start coalitions will provide prenatal care providers with information on the Healthy Start program to help increase screening rates and referrals into the program. **Standard 20.9 The coalition shall encourage prenatal care providers to refer recipients into Healthy Start in the coalition's service delivery area for reasons other than score, such as knowledge or suspicion of the following criteria:** *Criteria:* **20.9.a** Domestic violence; **20.9.b** Sexual abuse; **20.9.c** Other threatened violence, including child abuse;

	Standards & Criteria
Chapter 20: SOBRA Outreach Program (Cont.)	**20.9.d** Substance abuse; **20.9.e** Untreated mental illness including severe depression and suicidal tendencies; **20.9.f** Known history of abuse and neglect in family/household; **20.9.g** Pregnancy complication, such as maternal obesity, gestational diabetes, and hypertension; **20.9.h** Infant whose mother received late or no prenatal care; **20.9.i** Infant whose mother is at risk for a shortened interpregnancy interval; **20.9.j** HIV positive; **20.9.k** Hepatitis B positive; **20.9.l** Lack of basic needs such as housing and food; **20.9.m** Insufficient prenatal or pediatric care; or **20.9.n** Inappropriate growth and development of the baby/fetus **20.9.o** Smoking in the household in which infant will live. **Standard 20.10 The coalition, or its subcontracted provider, shall compile information about language skills of prenatal care providers and their office staff and provide recipients with this information when requested.** *Criterion:* The coalition, or its subcontracted provider, must identify what language skills the prenatal care providers or staff possess and have this information available for enrollees during their prenatal care provider decision-making process.

	Standards & Criteria
Chapter 21: Healthy Start Services Interconception Education and Counseling	**Standard 21.1 Healthy Start interconception education and counseling services will be offered to all participants who are determined through the care coordination process to need them.** *Criteria:* **21.1.a** Level of service is based upon local resources, local Healthy Start coalition funding decisions, and consideration of Healthy Start as the payer of last resort. **21.1.b** Interconception education and counseling services will be provided with consideration to the cultural, language, educational/literacy, and accessibility needs of the participant. **21.1.c** With the participant's approval, fathers, significant others, and other household members are encouraged to participate in the education process. **21.1.d** Interconception education and counseling services include the following components: • Assessment; • Development of a plan of care; • Counseling and education consistent with the plan of care and approved curriculum that includes presentation, follow-up, and feedback; and, • Evaluation of progress. **21.1.e** Interconception education and counseling services follow an established curriculum approved by the Healthy Start Coalition. **21.1.f** Providers of interconception education and counseling services assure classes and support services are prevention-based and adaptable to reflect participant needs. **21.1.g** The duration of interconception education and counseling classes or individual sessions is specified in contracts and memoranda of agreement. **21.1.h** Interconception education and counseling services include at least one information session and additional sessions based on identified need.

	Standards & Criteria
Chapter 21: Healthy Start Services Interconception Education and Counseling (Cont.)	**Standard 21.2 The provider of interconception education and counseling services will provide follow-up information to the Healthy Start care coordinator.** *Criterion:* Written follow-up documenting receipt of referral and plan for initiation of services is provided to the Healthy Start care coordinator within 30 days. **Standard 21.3 Providers of interconception education and counseling services will offer and initiate services in a timely manner.** *Criterion:* Interconception education and counseling services are initiated within 30 days after receipt of referral or identified need unless the need for more immediate initiation of services is evident. **Standard 21.4 Providers of interconception education and counseling services will respond to any additional identified needs.** *Criteria:* **21.4.a** Additional identified needs are addressed directly by the provider or by coordination with the participant's Healthy Start care coordinator. **21.4.b** Interconception education and counseling service providers communicate with the care coordinator who develops the individualized plan of care, and will collaborate as a part of the interdisciplinary team as indicated by individual need. **Standard 21.5 Providers of interconception education and counseling services will accurately code service information in a timely manner for Health Management Systems (HMS) data entry.** *Criterion:* Coding complies with the requirements of the Department of Health publication DHP 50-20.

	Standards and Criteria
Chapter 21: Healthy Start Services Interconception Education and Counseling (Cont.)	**Standard 21.6 Providers of interconception education and counseling will document services in the participant's existing clinical record or, in the absence of a clinical record, in a format determined by the local coalition and provider.** Criteria: **21.6.a** Documentation of services is recorded in the record of the individual receiving services. In the event that services are provided on behalf of a participant, the services are only referenced in the Healthy Start program participant's record (the actual documentation occurs in the recipient's record). **21.6.b** Documentation occurs in other components of the record such as the problem list or family support plan, as appropriate. **Standard 21.7 Interconception education and counseling service providers will develop and implement an internal quality management /program improvement (QM/PI) process.** *Criterion:* The QM/PI process is developed in concert with the local Healthy Start coalition and includes an assessment of strengths and areas needing improvement and a plan for assuring maintenance of quality and program improvement. **Standard 21.8 Interconception education and counseling services will be provided by qualified and trained providers.** *Criteria:* **21.8.a** Qualifications and services are met as outlined in this chapter and as specified in rule 64F-3.006, F.A.C. **21.8.b** Competency and up-to-date knowledge related to interconception education and counseling is maintained.

	Standards & Criteria
Chapter 22: Community Involvement	**Standard 22.1 Healthy Start Coalition membership shall represent the racial, ethnic, and gender composition of the catchment population**. *Criteria:* **22.1. a** The Coalition shall, in accordance with 383.216 (5), F. S. and 64F-2, F.A.C., recruit population representation in collaboration with local community organizations and other resources. **22.1.b** The Coalition shall provide evidence of Coalition membership and staff representation and evidence of outreach and activities to recruit representative membership and staff. **22.1.c** The Coalition shall assure that all members have been trained in their roles, responsibilities, and limitations. **Standard 22.2 The Healthy Start Coalition shall make every attempt to hire subcontractors and Coalition staff that represent the racial, ethnic, and gender composition of the catchment population.** *Criteria:* **22.2.a** In the recruitment and hiring of Coalition subcontractors and staff, there should be consideration of the balance between the demographics of the areas in need and the demographics of the Coalition catchment area. **22.2.b** The Coalition shall provide evidence of staff and subcontractor representation and evidence of outreach and activities to recruit representative staff and subcontractors. **Standard 22.3 Healthy Start Coalitions shall establish relationships with community leaders and organizations to develop processes and support for community involvement, mobilization, and advocacy.** *Criteria:* **22.3.a** The Coalition shall provide evidence of their relationships with community leaders and organizations and involvement in the Healthy Start program and services.

	Standards & Criteria
Chapter 22: Community Involvement (Cont.)	**22.3.b** The Coalition, through the funding allocation process, shall assure that community-based and grassroots organizations have the opportunity to participate in the provision of Healthy Start services. **Standard 22.4 Community-based and grassroots organizations shall be involved in the needs assessment, strategic planning, funding allocation, implementation, and evaluation processes that define perinatal health issues/problems, potential solutions, and strategies.** *Criterion:* **22.4.a** The Coalition shall provide evidence of community representation in all areas of program development, implementation and evaluation. **Standard 22.5 The Coalition shall consider current social, psychosocial, economic, and environmental issues in the community that impact perinatal health outcomes in their planning process. The Coalition shall create or take advantage of opportunities that address these community issues.** *Criteria:* **22.5.a** The Coalition shall assure and provide evidence that there is community participation, engagement, and involvement in Coalition activities, projects, and committees that address perinatal health outcomes. **22.5.b** The Coalition shall be actively involved in community-based activities, projects, and committees and provide evidence of this involvement. **Standard 22.6 The Coalition shall regularly report to the community on services, education, and health outcomes through the utilization of various communication methods that are appropriate for diverse segments of the population.** *Criteria:* **22.6.a** The Coalition shall tailor the approach, content, and delivery of communications in a manner that is appropriate for diverse segments of the population. **22.6.b** The Coalition shall develop and utilize specific communications for the population most affected by poor perinatal outcomes.

	Standards & Criteria
Chapter 22: Community Involvement (Cont)	**Standard 22.7 The Coalition shall provide orientation, on-going information, training, and assistance to the community-at-large, Coalition membership, and community/faith-based organizations on perinatal issues and trends.** *Criteria:* **22.7.a** The Coalition shall assure that all Coalition members receive orientation and training on the service delivery planning process. **22.7.b** The Coalition shall take the responsibility for assuring that the community has a knowledge base regarding perinatal issues and trends. **Standard 22.8 The Coalition shall provide cultural competency training for all Healthy Start Coalition staff and board members.** *Criterion:* **22.8.a** The Coalition shall provide evidence of cultural competency training to Healthy Start Coalition staff and board members. **Standard 22.9 The Coalition shall facilitate cultural competency training for Healthy Start subcontracted providers and membership.** *Criteria:* **22.9.a** The Coalition shall either directly provide or assure the provision of cultural competency training to Healthy Start subcontracted providers and membership. **22.9.b** The Coalition shall provide evidence of cultural competency training provisions to Healthy Start subcontracted providers, Coalition staff and membership. **Standard 22.10 The Coalition shall provide a mechanism for feedback from the community and Healthy Start subcontracted providers regarding Coalition member representation, Coalition activities, community inclusion efforts, and communication processes.** *Criteria:* **22.10.a** The Coalition shall provide evidence of feedback mechanisms through the service delivery planning process.

	Standards & Criteria
Chapter 22: Community Involvement (Cont.)	**22.10.b** The Coalition shall provide evidence of feedback received through the service delivery planning process. **Standard 22.11 The Coalition shall establish a mechanism for feedback from the Healthy Start service consumers regarding Healthy Start subcontractors.** *Criteria:* **22.11.a** The Coalition shall provide evidence of the established feedback mechanisms and feedback received from Healthy Start service consumers regarding Healthy Start subcontracted providers and staff on an annual basis, at minimum. **22.11.b** The Coalition shall provide evidence of analysis and appropriate follow-up actions performed in response to feedback received on an annual basis, at minimum.